

Ellner Bariatric

Ellner Bariatric
5555 Reservoir Drive, Suite 203
San Diego, CA 92120
Phone 619-286-7866

Email form to: ellnerpreop@gmail.com
OR Fax to 619-286-7867

Website: Ellnerbariatric.com

Requested Procedure:

Last name, First, Middle	Date of Birth	Sex	Marital Status M D S W
Street Address	Home Phone		Cell Phone
City State Zip code	Social Security #		FAX Number
Employer's Name	Email Address		
Employer's Street Address	Work Phone		Drivers License# & State
City State Zip code	Occupation	Race/Ethnicity	
Emergency Contact: Relationship	Cell Phone		Religious Preference
Street Address, City, State, ZIP	Home Phone		Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? Former patient TV Newspaper ad Internet Magazine Radio
website: www.ellnerbariatric.com Friend **Physician's Name:** _____
Date attended or watched video Seminar _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Signature: _____ Date: _____

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PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

Name:	Date:	Age:
Occupation: (If retired or disabled, what <i>did</i> you do or what is your disability?)		
Weight	Height	BMI
		Body Frame – Circle One Small Medium Large

WEIGHT HISTORY

What is your highest weight in the last 5 years ? _____ What is your lowest weight in the last 5 years? _____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
OptiFast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Meridia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Lindora	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
O.A.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Metabolife	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Other:		_____	_____	_____	_____

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List any physician-supervised and documented weight loss attempt:

List any other diets and/or weight loss methods you've tried:

For female patients only:

Pregnancy #1 Year _____ Weight at start _____ at delivery _____

Pregnancy #2 Year _____ Weight at start _____ at delivery _____

Pregnancy #3 Year _____ Weight at start _____ at delivery _____

Pregnancy #4 Year _____ Weight at start _____ at delivery _____

Food and Exercise History

What are your dietary pitfalls? (circle answers)

Snacking stress eating grazing all day love sweets eating large meals fast foods
Love salty love crunchy skipping meals restaurants boredom love carbs
Other _____

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What do you do for exercise:

Difficulty with exercise is due to (circle answers): shortness of breath joint discomfort

back pain lack of motivation lack of time embarrassment time

scheduling family other: _____

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes No

If Yes: ♦ Year Diagnosed _____

Do you have, or have you had:

Angina

M.I. (myocardial infarction, "heart attack"), stroke, mini-stroke (TIA)

CABG (coronary artery bypass graft)

Abnormal EKG

Stress test to rule out cardiac problems

Palpitations, Fast Heartbeat (tachycardia), Slow Heartbeat (bradyarrhythmia)

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2. High Cholesterol Yes No High Triglycerides Yes No

If Yes: ♦Year Diagnosed _____

♦List medications _____

3. High Blood Pressure Yes No

If Yes: ♦Year Diagnosed _____

♦List medications _____

4. Diabetes Yes No

If Yes: ♦Year Diagnosed: _____

♦Gestational: Yes No

♦Neuropathy: Yes No

♦Controlled with: Diet

Oral Medication (list) _____

♦Last fasting blood sugar: _____

5. Asthma Yes No

If Yes: ♦Year Diagnosed: _____

♦ER visits/last 2 yrs: _____

♦Hospitalizations last 2 years: _____

♦Steroids last 2 years: Yes No

6. Shortness of breath Yes No

If Yes, : ♦Can walk _____ blocks

♦Stairs: _____ flights

7. Trouble Sleeping? Yes No ♦Observed apneas Yes No

♦Morning headaches Yes No

♦Arm/Leg Twitching(PLM's) Yes No

♦Grinding of teeth/jaw Yes No

♦Excessive Daytime Fatigue/sleepiness Yes No

♦ Restless sleep Yes No

♦Snoring Yes No

♦Awakenings at night Yes No

Office Use: *sleep study ordered*

8. Sleep Apnea Syndrome Yes No

If Yes: ♦Year Diagnosed: _____

♦Last sleep study: _____ month/year

♦CPAP used: Yes No

9. Heartburn/esophagitis/hiatus hernia? Yes No

If Yes: ♦Year Diagnosed: _____

♦Upper GI series? Yes No

♦Endoscopy? Yes No

♦Medications: _____

♦Frequency of use: _____

Office Use: *UGI/endoscopy ordered*

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10. Belching up acid or sour fluid. Yes No

11. Coughing or choking at night? Yes No

12. Gallbladder disease? Yes No

If Yes: How was it Diagnosed? Ultrasound Physical Exam (Gallbladder removed)

13. Leakage of urine with laughing/coughing/sneezing? Yes No

If Yes: ♦Wear pads frequently? Yes No

15. Low back strain/Pain/Sciatica? Yes No

If Yes: ♦Seen by Chiropractor? Yes No

♦Orthopedic Surgeon? Yes No

♦Seen by Family Doctor? Yes No

♦Medications taken: _____

16. Pain in Hips/Knees/Ankles/Feet? Yes No

If Yes: ♦Seen by Chiropractor? Yes No

♦Orthopedic Surgeon? Yes No

♦Seen by Family Doctor? Yes No

♦Medications taken _____

17. Weight related injuries and trauma: _____

18. Venous Stasis Disease? Yes No

If Yes: ♦Do you have Edema? Yes No (edema is swelling in the lower legs or feet)

♦Scaly & Thick Skin? Yes No

♦Leg Ulcers? Yes No

19. Gout? Yes No

If Yes: ♦Gouty Arthritis? Yes No

Using Medication? _____

OTHER PAST MEDICAL HISTORY

Female Patients:

Number of pregnancies: _____

Age at first period: _____

Number of live births: _____

Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications: _____

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Do you presently use:

Birth control pills Yes No List type: _____

Estrogens Yes No List type: _____

Other Contraceptive method: _____

When was your last mammogram? Date _____ **Results** _____

Please identify which of the following childhood illnesses you have experienced:

- Measles Mumps Chickenpox Obesity
 Rheumatic fever Heart murmur Asthma Tonsillectomy

Have you had:

- Hepatitis Blood Transfusion AIDS/HIV Exposure
 Colitis Kidney Disease Bleeding Abnormality
 Thyroid Problems Cancer, type: _____

Would you accept a blood transfusion in an emergency situation? _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Major Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Allergic to any medications?: Yes No If Yes, please list medication and reaction:

Allergic to: **Surgical tape:** Yes No **Latex:** Yes No **Iodine:** Yes No

Other Allergies:

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Please list all medications you currently use, including vitamins and supplements

Medication	Dose	Frequency

Do you use THC/Hookah: Yes No Frequency/Type: _____

Do you use tobacco: Yes No Frequency/Type: _____

Are you willing to quit? Yes No

Have you ever used tobacco? Yes No How many Years? _____

How many packs a day? _____

Do you use alcohol: Yes No Frequency: _____

Drug Use (social): Yes No Frequency: _____ Type: _____

Any history of abuse: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- | | |
|--|--|
| <input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Lung disease, Asthma or Emphysema
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bleeding tendency or Blood Disorder
<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Colon Cancer |
|--|--|

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SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze – decreased sex drive

◆ Men: discharge from penis – loss of erection – painful erection

◆ Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods – lack of orgasm

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – x-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

OTHER:

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Personal Physicians:

Please list all the physicians under whom you receive medical care:

	<u>Name</u>	<u>Address/Location</u>	<u>Fax & Telephone</u>
Primary Care Physician	_____	_____	_____
	_____	_____	_____
Internist	_____	_____	_____
	_____	_____	_____
Gynecologist	_____	_____	_____
	_____	_____	_____
Orthopedist	_____	_____	_____
	_____	_____	_____
Psychiatrist	_____	_____	_____
	_____	_____	_____
Psychologist	_____	_____	_____
	_____	_____	_____
Therapist	_____	_____	_____
	_____	_____	_____
Nephrologist	_____	_____	_____
	_____	_____	_____
Other (Specify)	_____	_____	_____
	_____	_____	_____

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Patient Name

Date of Birth

Address

Social Security Number

City, St Zip

Phone #

I authorize _____ (name of your doctor or hospital) to release copies of my medical records, created during the course of my diagnosis and treatment at your facility, and for continued patient care, to:

Ellner Bariatric (fax) 619-286-7867 (Phone) 619-286-7866

Approximate Dates of Service for requested Medical Records: _____

I understand the information is released for continued patient care and may not be provided in whole or in part to any other agency, organization or person. I hereby waive my/his/her rights to the privileges of confidentiality with respect to any HIV test result or mental health information or drug/alcohol information that may be contained in the medical record. The Healthcare provider, its employees and officers and attending physicians are released from legal responsibility or liability for the release of information to the extent stated and authorized herein. Records may be faxed to expedite continuing care. This authorization is valid for 180 days from date of signature unless revoked in writing earlier by the patient.

Signature of Patient

Date

Signature of Parent/Guardian/Legal Representative

Relationship to the Patient

This fax contains **CONFIDENTIAL INFORMATION** and is only for the individual or entity named in this document. Otherwise, you are hereby notified that disclosure, copying, distribution or other action to the content for this fax is strictly prohibited. If this is received in error, please contact sender immediately.

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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name (please print)

Date of Birth

Both before and after surgery we will need to contact you regarding test results, insurance information, referrals, etc. We will need your authorization to convey this protected health information in a way that is most convenient for you.

Designated method of contacting the patient (check all that apply)

____ OK to leave detailed messages on answering machine (____) _____

____ OK to leave detailed messages on voice mail (____) _____

____ Leave call back messages only (____) _____

____ Send detailed messages via e-mail _____
E-mail address

____ Please check if your e-mail is confidential and should NOT be used

Signature

Date

Ellner Bariatric

5555 Reservoir Drive, Suite 203
San Diego, CA 92120

(619) 286-7866 phone
(619) 286-7867 fax

Appt Cancellation and Late Payment Policy

In consideration of the great number of patients desiring appointments, there will be a \$75 fee charged to anyone cancelling an appointment within 24 hours of the scheduled time. Payment will be required before another appointment will be scheduled.

Thank you for your cooperation

_____(Initial)

Email Communication with Patients

Our patients communicate a great deal with the office and most find that email is the most efficient method. Because of patient privacy laws, we need your permission to correspond via email. Please read the following carefully.

I authorize Ellner Bariatric to use unsecured email for communicating with me regarding my medical condition. I understand that commonly used email does not protect my personal information from possibly being available on the internet. Unencrypted email is not HIPAA (Patient Privacy) compliant. With my signature below, I permit the use of such email correspondence with Ellner Bariatric.

_____(Initial)

Policy Regarding Pets

At Ellner Bariatric, we love pets of all shapes and sizes. However, in order to maintain a clean environment for our patients with fresh surgical incisions, as well as a clean area for sterile dressings, we cannot allow pets of any kind in the exam rooms. This includes service and support animals. If your disability requires that you have personal assistance, we ask that you make arrangements to bring a caregiver to your appointment(s), so you will be comfortable while still maintaining the safety of others. We greatly appreciate your assistance in maintaining a clean, infection free environment.

_____(Initial)

Receipts for Services

It is our practice to provide all receipts to you directly at the time of payment. Please keep track of your receipts, so you can use them for taxes, HSA accounts, etc. Should you lose your receipts and require copies to be made, you will need to contact our biller, Lisa, who works off site. She will leave her billing office to locate your receipts in your files at Ellner Bariatric and merge them with your receipts in her billing system. This is an extremely time consuming process, so you will be required to reimburse her for her time. Please keep track of your receipts so you don't incur extra costs.

_____(Initial)

I understand and will comply with the above policies.

Signature and DATE

Printed Name

Ellner Bariatric, Inc